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AUTHOR Fasko, Sharla Nichols
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ABSTRACT

This paper reviews studies of childhood suicide and reports findings which suggest that the incidence of suicide under the age of 14 is greatly underreported. It notes that the incidence of non-fatal suicide attempts in children is even harder to determine than is the incidence of suicide. Studies are cited which suggest that, while preadolescent boys appeared to attempt suicide with much greater frequency that girls, the level of lethality in younger boys and girls was about equal. Reasons for a child to attempt suicide are considered, including self-punishment, escape, reunion with a significant other, rectification of an unbearable life situation, and avoidance of an impending punishment. Factors in suicidal behavior which are addressed include the child's conceptualization of death, depression, and familial factors (parental depression, family history of suicidal behavior, abuse, family instability, and life stress). It is concluded that there is no one cause of suicidal behavior in children, but that a number of determinants are involved. It is recommended that future research concentrate on providing a more accurate calculation of the incidence of suicidal behavior in children. Thirty-two references are included. (NB)

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Suicidal Behavior in Children

Sharla Nichols Fasko

University of Cincinnati

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Abstract

Studies of childhood suicide were reviewed. Findings indicate that the incidence of suicide under age fourteen is greatly underreported. Factors in suicidal behavior, including precipitating events, conceptualization of death, depression, and familial factors were examined. Implications for school personnel were discussed.

Suicidal Behavior in Children

A well-known psychologist once reported, "Suicides . . . are becoming more and more precocious. In these days children leave their [toys] . . . to commit suicide, tired of life almost before they have tasted it." Interestingly, this was written by Lewis Terman about 75 years ago (Terman, 1913, p. 43).

Today, psychologists usually report the incidence of childhood suicide in less dramatic terms, but the issue is still an emotional one. Most people are appalled at the idea that a pre-adolescent child would even consider taking his/her own life. Indeed, this was regarded as impossible for many years by the followers of Freud, who believed that children could not be depressed, and therefore could not be suicidal (Price & Lynn, 1986). Many adults consider children to be too unsophisticated to plan their own death (Celotta, Jacobs, & Keys, 1987).

While most authorities regard childhood suicide as a rare occurrence, there is some dissension as to the exact incidence. The U.S. Bureau of the Census (1988) reports the incidence of suicide in children ages 5 to 14 as a little less than 1%; however, they never record the deaths of children under age 8 as suicide, regardless of the information on the death certificate

(Cantor, 1983). In addition, coroners are reluctant to label a child's death as suicide, and when there is no suicide note (which is usually the case), they are more likely to call it an accident (McGuire & Ely, 1984). In fact, underreporting of suicides is considered a serious problem with the validity of official statistics (Fisher & Shaffer, 1984).

The incidence of non-fatal attempts in children is even harder to determine. Cohen-Sandler, Berman, and King (1982) estimated that about 12,000 children aged 5 to 14 are admitted annually to psychiatric hospitals because of suicidal behavior, but many more suicide attempts may be unrecognized as such. In a study of 101 randomly chosen school children ages 6 to 12, Pfeffer (1985) found that 12% had suicidal impulses. Boys appear to attempt with much greater frequency than girls, but, unlike adolescent attempters (where males select more lethal methods than do females), the level of lethality in younger boys and girls is about equal (Pfeffer, Conte, Plutchik, & Jerrett, 1979; Toolan, 1984).

Why would a child attempt suicide? A study of 16 preschoolers discerned four basic categories of reasons: self-punishment, escape, reunion with a significant other, and rectification of an unbearable life situation

(Rosenthal & Rosenthal, 1984). In addition, Kosky (1983) listed the reasons given by eleven suicidal children ages 5 to 12. For example, a five-year-old wanted to kill himself to be with his dead brother, because if he were dead, his mother would love him the way she loved his dead brother. A seven-year-old hoped to avoid being hit by a parent. In a study of 30 consecutive suicides of children under age 15, Shaffer (1974) found that the most common precipitating factor was an impending punishment. Thus, children display suicidal behavior for a variety of reasons.

Factors in Suicidal Behavior

Conceptualization of Death

There is some disagreement on the ability of children to understand the concept of death. In a study of 598 youngsters, ages 5 to 18, McIntire and Angle (1981) found that by ages 13 to 16, 60% believed in a spiritual continuation, and 20% believed that after they died they would still have consciousness. Those who were suicidal were more likely to have less realistic concepts of death. Others (e.g., Pfeffer, 1984) have suggested that when under stress, older children regress to a lower level of ego functioning, and are then more likely to perceive death as reversible.

According to Piaget (1954), children do not fully

understand the finality of death until they reach the formal operations stage, which is about midway into adolescence. In a study of 378 children, Nagy (1959) found three stages of death conception. In the first stage (3-5 years), death is regarded as temporary and not a regular occurrence in life. In the second stage (5-9 years), children personify death, and regard it as irreversible but existing outside of us. In the third stage (after 9-10 years), children recognize death as universal, inevitable, and taking place in all of us.

In their study of suicidal preschoolers, Rosenthal and Rosenthal (1984) found that those who attempted suicide in order to reunite with a loved one or to rectify an unbearable life situation perceived death as reversible and temporary. Those who made attempts as a means of self-punishment or to escape an intolerable life situation were aware of the irreversibility of death. This same study found that about 56% of the suicidal preschoolers were depressed according to Weinburg's depression scale (Weinburg, Rutman, Sullivan, Penick, & Dietz, 1973).

Depression

Many authorities have linked depression to childhood suicidal behavior. There is some disagreement, however, as to the manner and extent

depression is involved.

Terman (1913, p. 44) listed "melancholia" as one of the causes of juvenile suicide (in Terman's view, however, the influences of schools, mental disease, and mothers who show partiality to other children are even more dangerous). More recently, depression has been strongly linked with suicidal behavior in children. For example, based on his clinical experience, Toolan (1975) stated that "...the vast majority of youngsters who threaten suicide or attempt suicide are depressed to a significant degree..." (p. 341).

A study by Pfeffer, Plutchik, Mizruchi, and Lipkins (1986) appears to support Toolan's opinion. Three groups of children were assessed to identify factors associated with suicidal behavior. One hundred and one children (ages 6 to 12 years) were administered a large battery of research instruments designed to assess suicidal behavior, assaultive behavior, precipitating events, psychopathology, family background, concept of death, ego functioning, and ego defense. In all three groups (psychiatric inpatients, outpatients, and nonpatients), recent and past depression were significantly related to suicidal behavior.

In addition, a study by Cohen-Sandler, Berman, and King (1982) of 76 suicidal children ages 5 to 14

indicated that 65% were seriously depressed based on Weinburg's depression scale (Weinburg et al, 1973). In a similar study of 61 suicidal children ages 5 to 13, about 30% were diagnosed as depressed according to DSM-III (Myers, Burke, & McCauley, 1985). Likewise, Rosenthal and Rosenthal (1984), in their study of 16 suicidal preschoolers, found that about 56% of the children were depressed based on Weinberg's criteria.

It is clear that not all children who attempt suicide appear to be depressed. Some authors (e.g., Cohen-Sandler, Berman, & King, 1982) suggest that part of the problem may be with the criteria for determining depression in children. This could be due in part to the fact that for many years, psychologists denied the existence of depression in children (Price & Lynn, 1986).

Some researchers (e.g., Hetherington & Parke, 1986) have concluded that depression is of less importance that the hopelessness experienced by the children. This has been supported in studies of adults (Kovacs, Beck, & Weissman, 1975). In fact, recent studies have indicated that children experience hopelessness in much the same way that adults do (Kazdin, Rodgers, & Colbus, 1986).

Other researchers, however, believe that the depression is

actually present in these undiagnosed children, but is masked by other behaviors. For example, Pfeffer, Plutchik, and Mizruchi (1983) found that, while many suicidal children display intense depression, others show less depression but much more intense aggression. The authors suggested that this aggressive behavior may actually be a method of expressing depression. Toolan (1975, 1981), in discussing studies linking low self-esteem to suicidal behavior in children, pointed out that low self-esteem is an important symptom of depression, thereby supporting the evidence linking depression to childhood suicide. Depression may also be related to childhood suicidal behaviors through familial factors.

Familial Factors

A number of studies have indicated that parental depression is related to childhood suicidal behavior. For example, in a random sample of 101 school children, ages 6 to 12, Pfeffer (1985) found that those children expressing suicidal impulses were more likely to have depressed parents. In fact, a study of suicidal children ages 6 to 12 indicated that their parents were significantly more depressed than those of a nonsuicidal control group (Pfeffer, Conte, Plutchik, & Jerrett, 1979). Additionly, children who were suicidal and

assaultive were found to be characterized by depressed parents (Pfeffer, Plutchik, & Mizruchi, 1983).

A family history of suicidal behavior has also been linked to suicidal behavior in children. In a study of 61 suicidal children ages 5 to 13, a family history of suicidal behaviors was significantly greater than in a matched control group of nonsuicidal children (Myers, Burke, & McCauley, 1985). A similar study of 505 children and adolescents (ages unreported) who were suicidal and a matched control group, Garfinkel, Froese, and Hood (1982) found that there was significantly more family suicidal behavior in the suicidal group. Similar results have been found in other studies (e.g., Pfeffer, Conte, Plutchik, & Jerrett, 1979; Pfeffer, Plutchik, & Mizruchi, 1983).

Abuse appears to be present in the families of many suicidal children. For example, Green (1978) compared three groups of children: physically abused, neglected, and normal children. The abused children had a significantly higher rate of suicidal behavior than those in either of the other groups. In a group of 16 suicidal preschoolers, 81% were either abused or neglected, and a similar number were considered unwanted by their parents (Rosenthal & Rosenthal, 1984). When suicidal children ages 5-13 were compared to a matched

nonsuicidal control group, the suicidal children had significantly higher rates of abuse by biological fathers, and mothers who were abused (Myers, Burke, & McCauley, 1985). Similar results have been found in children ages 6 to 12 (Pfeffer, Plutchik, & Mizruchi, 1983).

A history of family instability has often been noted with suicidal children. Suicidal children were found to have experienced throughout their lives a greater number of parental separations, divorces, and remarriages than did a control group (Cohen-Sandler, Berman, & King, 1982). "Disordered family relationships" contribute heavily to suicidal behavior in children, according to Ford, Rushforth, and Sudak (1984, p.168).

The cumulative effects of life stress may also influence suicidal behavior. Myers, Burke, and McCauley (1985) found that suicidal children had experienced a recent stressful life event significantly more often than those in a matched control group. In a similar study, suicidal children experience significantly greater amounts of stress as they grew up, when compared to a matched control group (Cohen-Sandler, Berman, & King, 1982). Also, Weiner (1982) noted that suicidal behavior is often preceded by an escalation in family

problems.

An interesting theory of suicidal behavior in children was presented by Orbach (1986). He believed that suicidal children have been pressured into taking responsibility for a difficult family situation--an "insolvable problem." The child may be used as a weapon by parents against each other, or forced to take heavy responsibilities for which s/he is unprepared. The child then begins to feel trapped, and sees suicide as the only available alternative.

Implications

It would be a mistake to assume that children are too young to attempt or consider suicide. Regardless of whether they perceive death as permanent or temporary, children do make attempts to achieve death, and one must not discount overt or covert suicide threats simply on the basis of age.

Because children are often driven to suicide by the threat of punishment, perhaps, then, those children from very punitive families are at higher risk. Children in abusive situations seem to be particularly at risk for suicidal behavior. This is important to consider when working with troubled children or assessing lethality of a threat.

Other factors which may increase the probability

of suicidal behavior in a child are depression (in the child or a parent) and a family history of suicidal behavior. It is also important to consider the extent of family instability and recent and past life stress the child has experienced.

These factors taken alone cannot cause a child to attempt suicide. Weiner (1982) pointed out that family instability "affects young people only to the extent that they experience it as stressful" (p. 438). For example, a parental divorce may be perceived by one child with relief or indifference because of reduced strife, while another child may feel great distress.

Most authorities agree that family intervention is important in dealing with suicidal children (e.g. Weiner, 1982; McGuire & Ely, 1984; Toolan, 1975, 1981). Toolan (1981) stated that any therapy that does not include the family will be ineffective. Parents often have difficulty admitting that there is a problem, and that they are a part of it (Myers, Burke, & McCauley, 1985).

A limitation of many of the studies was a lack of normal control groups. While several studies did include control groups (e.g. Myers, Burke, & McCauley, 1985; Cohen-Sandler, Berman, & King, 1982), most used control groups involving a different diagnosis such as behavior disordered (Rosenthal & Rosenthal, 1984), or

physically or psychiatrically ill (Garfinkel, Froese, & Hood, 1982). This could prevent identification of certain distinguishing behavior patterns or characteristics of suicidal children.

An area for further research may be a more accurate calculation of the incidence of suicidal behavior in children. Perhaps a representative sample of emergency rooms could be monitored by people trained in detecting suicidal behavior. This would not detect all attempts, of course, but it should bring researchers a little closer to accuracy.

Apparently there is no one cause of suicidal behavior in children. The best explanation is that a number of determinants are involved. If we can discover what characteristics are most typical of suicide attempters, we can take preventive measures with those children who display these characteristics, and perhaps someday significantly reduce the rate of suicidal behavior in children.

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